

Research Articles

A qualitative study of health care providers' perceptions and experiences of patients bypassing primary healthcare facilities: a focus from Nigeria

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Background

The healthcare referral system is designed to ensure that patients receive the best care at the appropriate level, as well as improving access to different levels of care. However, approximately 60-90% of patients in Nigeria bypass their local primary level of care to seek healthcare outside of the community. This study is part of a larger mixed methods study that explored the patients' and healthcare providers' perceptions and experiences in order to understand the factors that influence a patient's decision to bypass the primary level of care to go to secondary and tertiary level facilities. In this study we present the perspectives of the healthcare providers and the factors that influence a patient's decision to self-refer, as well as their suggestions for how primary healthcare facilities can retain patients locally.

Methods

In-depth semi-structured interviews were conducted with eighteen healthcare providers comprising doctors, nurses, and community healthcare workers from primary and secondary healthcare facilities in Niger State, Nigeria. The interviews were tape recorded and subsequently transcribed. The analysis was carried out using the principles of framework analysis.

Results

The shortage of healthcare providers at local facilities was described as a key reason for patients to self-refer to secondary and tertiary care. Lack of basic equipment, inequitable distributions, and the inconsistent opening hours of the primary healthcare facilities were also considered to be influencing factors for bypassing the primary health facilities. In order to encourage the use of the primary healthcare facilities, some of the healthcare providers suggested ensuring that medical doctors were stationed within those facilities, and also suggested the need for collaboration between the different levels of care, as current services appeared fragmented.

Conclusions

Interventions such as employing the services of doctors (family physicians) and standardising the primary healthcare facilities in terms of distribution and availability of the basic facilities are needed to reduce the barriers associated with the bypass of the primary level of care in low cost economies. In addition, tangible policies that ensure the primary health facilities are well resourced should be enacted. The findings have implications for planning, practice, and policy in service delivery aimed at curtailing the bypass of the primary health care facilities.

Globally, healthcare delivery is arranged in a hierarchy of primary, secondary, tertiary, and/or quaternary levels. This hierarchy ensures that: the integrity of the different levels are maintained, with patients receiving the best care at an appropriate level; hospital facilities are used optimally and cost-effectively; patients in most need of specialist services are able to access them in an appropriate manner, and; primary health services are well utilised and not undermined.^{1,2} Despite the adoption of the Alma-Ata Declaration as the cornerstone of the Nigerian health system in 1987,³ healthcare delivery undertaken by Primary Health Care (PHC) facilities has struggled to gain relevance. Notwithstanding, the Nigerian healthcare system has witnessed several reforms since its independence in 1960.⁴ One

of the defining eras was the introduction of the Basic Health Services Scheme (BHSS) during the third National Development Plan (NDP) (1975-80).⁵ This saw the introduction and spread of PHC facilities such as health posts, primary health clinics, and primary healthcare centres.^{6,7} The fourth NDP (1981-85) further witnessed the enactment of policies for the provision of a comprehensive healthcare system offering promotional, protective, restorative, and rehabilitative services. This led to the formulation and development of a national comprehensive healthcare scheme, where healthcare services were provided across three levels (primary, secondary, and tertiary health facilities).⁸ However, despite the provision of care in three tiers, the Nigerian healthcare referral system has continued to be a challenging area, with

patients utilising the higher levels of care as they deem fit.^{8,9}

Some of the Nigerian healthcare indices have persistently remained poor, for example, the probability of dying at under-five as at 2016 was 120/1000 live births, and the life expectancy was 55 for males and 56 for females.¹⁰ Also, the maternal mortality ratio of 917/100,000 live birth is one of the highest in the world.¹¹ Healthcare financing in another aspect the government have struggled to address whereby out of pocket expenditure accounted for 77.7% of the total expenditure in 2017.¹² Other issues of concern that have and continue to impact on the healthcare system in Nigeria are inadequate incentives, inadequate health workforce, poor equipment and infrastructure.¹³ Despite these poor indices, the total expenditure on healthcare is about 3.76 per cent of the total Gross Domestic Product (GDP) of the country.¹⁴ This is contrary to the Abuja Declaration of 2001, which the Heads of State for African Union countries pledged to allocate at least 15% of their total annual government budgets to the health sector.¹⁵

The provision of functional PHC facilities remains imperative in any healthcare system; without this, the secondary and tertiary levels of care would be overwhelmed with cases that could be effectively dealt with at the PHC level.¹⁶ It is equally important that hospitals do not offer treatment that could be provided by the primary levels of care; if they did, it would become overloaded and they would be unable to provide proper support to the community.¹⁷ In tandem with this observation, findings show that approximately 60-90% of patients in Nigeria bypass the PHC facilities to go to the higher levels of care.¹⁸⁻²⁰ As such, the secondary and tertiary facilities have become overcrowded with patients that could have been easily managed at the PHC facilities.^{5,9}

Notably, healthcare delivery differs from one setting to another. Thus, the problem concerning the bypass of primary to higher levels of care takes different forms based on the context.²¹ Attempts have been made to understand the factors that facilitate or impede the circumvention of primary level facilities to higher level facilities in different settings. Findings have shown that factors such as healthcare insurance,^{22,23} knowledge regarding the healthcare delivery system²⁴⁻²⁶ and access to healthcare facilities²⁷⁻²⁹ are all associated with patients seeking care at referral facilities. Additional factors identified include the availability of healthcare providers and equipment.³⁰⁻³² However, studies exploring healthcare providers' perspectives on this subject have been sparse, and have mainly emanated from developed settings.³³⁻³⁵ Healthcare providers and patients remain important co-actors in shaping and modelling the healthcare delivery system. Accordingly, the perspectives of these co-actors are noted as driving the quality of care within the healthcare system.³⁶ Therefore, this study aims to explore the perspectives of the healthcare providers and thus identify some of the factors that may influence a patient's decision to self-refer.

METHODS

The study protocol for this study was approved by the Institute for Health Research Ethics Committee at the University of Bedfordshire and the National Health Research Ethics Committee (NHREC) of Nigeria. Written informed consent was obtained from each participant. Participants were selected via a purposive sampling technique from the primary and secondary healthcare facilities in Niger state, Nigeria. Due to their potential knowledge regarding the referral

processes and challenges involved, the target was to recruit healthcare providers who attended to patients at the public PHC facilities and secondary healthcare facilities. Therefore, participants included nurses and community health workers (CHWs) from the primary level facilities, as they are the principal care providers at that level. Doctors were recruited from the secondary healthcare facilities because they are mainly involved in carrying out consultations at the General Outpatient Department (GOPD). All participants were provided with participant information sheets before they consented to participate. A total of eighteen healthcare providers were interviewed, comprising six doctors from the secondary healthcare facilities, six CHWs, and six nurses from the PHC facilities (Table 1).

An in-depth semi-structured interview was employed for this study,³⁷ the interviews were tape recorded, and the duration of the interviews ranged between 15 and 34 minutes. All the interviews took place on the premises of the different healthcare facilities during working hours (between 08:00 and 16:00). Participants were asked questions surrounding: the functions of the different levels of the Nigerian healthcare system (primary, secondary, and tertiary levels), the process involved when referring or receiving a patient from another facility (higher or lower), factors that may facilitate or serve as barriers to bypassing the PHC facilities, and probing for the roles of opening hours, waiting times, transport, fees, equipment, and healthcare providers if not mentioned. Questions were also related to suggestions for curbing the bypass of the PHC facilities. These questions took cognisance of findings from the literature and from the researcher's experiences.³⁷ All interviews were transcribed by the researcher.

DATA ANALYSIS

Framework analysis was adopted for the analysis of the data using the five stages of the framework approach, including: 1) *familiarisation with the data* – the transcripts were read by all members of the research team; 2) *identifying a thematic framework* – themes were compared and discussed among the research team and a consensus was reached; 3) *indexing* – the themes were subsequently applied to the textual form of all the transcribed data using the NVivo10 software; 4) *charting* – to aid with tracking the account of each participant's transcript, a spreadsheet was created where the Page(P) and Line(L) numbers depicting the quotes from each participant that fit within the identified themes were placed in the respective cells; 5) *mapping and interpretation* – finally, the charts were reviewed to make connections between and within participants, seeking explanations for the patterns of the data.^{38,39}

RESULTS

The analysis of the transcripts revealed five themes that were related to: unmet expectations at the PHC facilities, lack of manpower and preference for doctors, lack of equipment or facilities, access to healthcare facilities, and government regulations (policies).

UNMET EXPECTATIONS AT THE PHC FACILITIES

It was generally perceived by the participants that patients have an expectation regarding their care at the PHC facilities, and if not met, this results in them seeking care at a higher-level facility.

■ "The patients want the best and sometimes when they

Table 1: Socio-demographic characteristics of participants (healthcare providers)

Identification no.	Age	Gender (M=male; F=female)	Duration of practice	Facilities
Doctor1	32	M	4 years	General Hospital Tafa
Doctor2	37	M	7 years	General Hospital Tafa
Doctor3	40	M	8 years	General Hospital Lapai
Doctor4	40	M	7 years	General Hospital Lapai
Doctor5	37	M	5 years	General Hospital Wushishi
Doctor6	43	M	6 years	General Hospital Wushishi
Nurse1	35	F	13 years	PHC Tafa
Nurse2	44	F	26 years	PHC Tafa
Nurse3	30	M	8 years	PHC Lapai
Nurse4	41	M	3 years	PHC Lapai
Nurse5	55	F	35 years	PHC Wushishi
Nurse6	58	M	29 years	PHC Wushishi
CHW1	33	F	13 years	PHC Tafa
CHW2	46	M	25 years	PHC Tafa
CHW3	35	M	4 years	PHC Lapai
CHW4	37	F	15 years	PHC Lapai
CHW5	51	M	25 years	PHC Wushishi
CHW6	40	F	28 years	PHC Wushishi

go to primary health centres, they spend money, time and at the end they don't get what they want. Also, it's the issue of confidence in the primary health centres. From what people have heard, they prefer to say no, no I don't just want to gamble with my health, let me go straight to where I will get the best." Doctor4.

They also talked about the poor relationship between the patients and healthcare providers. This was mainly highlighted by the healthcare providers within the PHC facilities (CHWs and nurses), who pointed out that when there is poor rapport between the healthcare providers and their patients, there is a tendency to seek care elsewhere.

"There are also relationship issues... it's funny to find out that there is a health facility with a health worker, but there is no good rapport between them [patients] and the health worker. So, they can bypass and decide to go to the bigger hospital." Nurse5.

Consequently, one of the participants felt that ensuring a good rapport between the healthcare providers and their patients is likely to encourage patients to utilise the PHC facilities. He explained how visiting patients at their homes, with patients having easy access to him, tends to strengthen their relationship and motivate the utilisation of the PHC facility where he works.

LACK OF MANPOWER AND PREFERENCE FOR DOCTORS

The idea that patients want to be seen by a 'doctor' was a common perception among the participants. This view cut across the different groups of healthcare providers (doctors, nurses, and CHWs) who were interviewed. Participants noted that the absence of medical doctors at the PHC facilities deters patients from presenting to those facilities, despite the availability of nurses and CHWs.

"We don't have a doctor here (PHC facility)... So that is one of the factors why they [patients] are bypassing this hospital, the primary healthcare to the secondary healthcare." Nurse3.

Aside from the lack of doctors in the PHC facilities, the general shortage of healthcare providers at these facilities was also highlighted as a deterrent to using them. Interestingly, some of the doctors spoke about the competencies of the healthcare providers providing care at the PHC facilities, who are primarily the nurses and CHWs. It was stated that patients likely feel uncomfortable receiving care from the CHWs, which might impact on their use.

"Most people are not comfortable with community health extension workers attending to them. It's just a psychological problem... it's sad actually and unsafe, that's the truth." Doctor1.

Some of the suggestions from participants regarding the above barriers included the need to have not only trained and qualified staff at the PHC facilities, but doctors especially. Specific reference was made to having National Youth Service Corps (NYSC) doctors who are referred to as 'corpers' (these are the fresh medical graduates who are posted for their one-year mandatory national service) available at the PHC facilities. This was viewed as a potential means to encourage patients to utilise the PHC facilities.

"Primary healthcare should have at least a resident doctor, one that will be able to give the necessary obstetric care, which most of the PHCs are lacking... It's imperative that a doctor should be positioned there to assist." Doctor3.

"...a doctor is supposed to be attached to each health facility, like this primary health facility is supposed to have at least a corper attached to it. You know, if we have that, we will have more clients." Nurse6.

Participants also suggested the need for collaboration between the different levels of facilities, believing it would decrease the burden on the secondary level of care and also encourage the use of the PHC facilities.

LACK OF EQUIPMENT OR FACILITIES

The different cadres (doctors, CHWs, and nurses) of participants perceived that the absence of facilities or equipment such as those used for investigations and drugs at the primary level of care was possibly related to the patients' decisions to sidestep them.

"Maybe they [patients] feel we don't have enough facilities... Can't you see? Like you can see now, this place is somehow shabby and rough. Some people look at the environment before they come in. Some people even come in and go out because they feel the place is not convenient for them." CHW1.

Some of the participants (mainly the nurses and CHWs at the PHC facilities) voiced their displeasure regarding the level and state of equipment within their facilities.

"The environment scares people... The equipment too, if this place [PHC facility] operates at a good standard, people will not bypass us [PHC facilities] to the general hospital. The equipment we use are not sterilised; you understand. We use stove and jik to sterilise our instrument. We are supposed to have autoclave to do all those things. The environment, in short, we are not satisfied with the equipment in comparison to the general hospital." Nurse1.

To avoid circumventing the primary level of care, participants suggested the need to have different facilities in place within the PHC setting. The facilities suggested included renovation of the physical structure of the PHC facilities, availability of medications, and provision of investigation equipment.

ACCESS TO THE HEALTHCARE FACILITY

AVAILABILITY OF PHC FACILITIES

One of the participants noted that the locations of the PHC facilities are not prioritised, pointing out that some areas have multiple facilities whereas others lack any of these facilities, thus prompting self-referral. They also emphasised that it was the political office holder who sited these facilities without proper consultation, and only for political gain.

"Now if I take you to one of the wards (community), you will discover that one of the wards has more than the necessary health facility. One village has about three health facilities, just because they have the advantage of having political officers. Do you understand? Whereby around that village, there are other villages that need a dispensary but they don't have." CHW5.

PROXIMITY OF PHC FACILITIES

The proximity of a secondary healthcare facility to patients was also perceived as a reason that could prompt patients to self-refer, especially if their closest PHC facilities are miles away from where they reside.

"Some could be due to the proximity to them, you know. I can't be going to the primary health centre that is like 7 kilometres from me and I have a secondary health centre that is 2 kilometres away from me." Doctor4.

AVAILABILITY OF SERVICES

The healthcare providers spoke about the role of the opening and closing hours of the PHC facilities. Participants observed that sometimes the PHC facilities might be closed for a particular function, such as when the healthcare providers needed to go into the communities to immunise children. However, this was linked to the lack of adequate staff to provide cover at these facilities.

"Most of the health facilities we have in remote areas now only have one person per health facility. Now we use to carry out these community activities, this ad hoc assignment, like immunisation or whatsoever. So, if that officer in charge leaves that clinic, when there is any case from the community, automatically for those four days you can't see him or her. So, they go straight to the secondary healthcare facility where they think they will definitely meet a personnel." CHW5.

Other participants also pointed out that the secondary healthcare facilities are open 24 hours a day, in contrast to the irregular opening hours of the PHC facilities, which they perceived as also playing a role in patients bypassing the PHC facilities.

"When you go there [PHC facility] you won't meet them [PHC staff] at work... I want to say they don't have 24 hours service there, so when you go there at night you will not meet anybody. So, you have to come to the secondary facility." Doctor6.

COST OF HEALTHCARE SERVICES

It was remarked that services are likely cheaper at the PHC facilities due to the availability of free medications for some specific medical conditions. Nevertheless, it was pointed out that the irregular nature of the services provided by the PHC facilities cannot be depended on by the patients.

"What if the medication is irregular? Just as I told you, when you need services, you can't get services when you need it. Of course, you have to go to another place, even if it is for free here [PHC facility]. But you can't find the health worker, so do you wait until he comes back? You can't wait. You have to move to where you can even pay money for you to secure your life." CHW5.

However, one of the doctors specifically noted that there is no significant difference between the service charge at the primary and secondary healthcare facilities. He emphasised that the increased cost of care experienced by patients at the secondary healthcare facilities is probably a result of investigations carried out at those facilities, which are not available at the PHC facilities.

"Well, the fees are the same thing. It is the same because cards here are being given for twenty naira. It's the same thing with primary health. Most of the investigations are done free, like malaria parasites, HIV screening... So, if you look at it that way, the fees might just be due to other investigations, like you now tend to talk of other higher investigations, where the patient have to pay." Doctor3.

Interestingly, it was also highlighted that patients who utilise the PHC facilities were perceived as people who do not have the financial capacity to use the secondary healthcare facilities.

"People that will rather patronise them [PHC facility] are people that might not have the financial capability." Doctor1.

Reducing the cost of care for patients at the PHC facilities was suggested as a possible option to encourage the utilisation of the PHC facilities. One of the participants also suggested the need for adequate PHC facilities, and equitable distribution of these facilities within the community, to help decrease the bypass of the PHC facilities.

"The primary healthcare facilities in the first place have to be enough and properly placed, because we have this problem of placement of health facilities. Some of the placements are politically motivated. There are places that really need health facilities but you will discover that these buildings are not there... So, the health facility has to be properly sited." CHW5.

LOCAL REGULATIONS AND POLICIES

Participants (mainly doctors) also noted that the government have a vital role to play in ensuring that tangible policies are put in place to curtail the bypassing of the primary levels of care.

"I think the government has to play a role... until when there is solid policy on ground... stating, for anything that happens to you, you have to pass through the primary health centre before you go to secondary healthcare." Doctor6.

A further suggestion was the need for the government to institute different financial charges between the secondary and PHC facilities, whereby patients who self-refer are made to pay more, with the aim of discouraging self-referral.

"Government can toe the line of action, where they have a basic standard cost for secondary healthcare, primary healthcare. So, people know even though you are going there... directly to the secondary health centre, you know you are paying extra for it." Doctor2.

DISCUSSION

Some of the reasons the healthcare providers suggested as being likely to influence the bypass of the PHC facilities included the preference by the patients to be attended to by medical doctors, and the lack of manpower at the PHC facilities. Interestingly, the medical knowledge of some of the staff rendering care at the PHC facilities was questioned, mainly by the participating doctors. These findings echoed the views of the patients from a previous study, who feared they could be given a wrong diagnosis by the healthcare providers within the PHC facilities.⁴⁰ The understanding among the patients that the majority of healthcare providers at the primary level of care were either CHWs or nurses further amplified this concern, thus they voiced their preference to be attended to by doctors who are mainly only available at the higher levels of care.⁴⁰ A similar finding was reported in the UK, whereby some patients felt the doctors at the emergency department had better knowledge than their general practitioners, which resulted in seeking care at the referral facility.⁴¹ Likewise, it's been found that the availability of staff alone does not ensure the delivery of quality care, as healthcare providers can lack the ability to make accurate diagnoses or to appropriately manage patients.³⁶ In line with this concern, several studies^{42–45} have suggested reconsidering prioritising the service delivery of family physician specialists in Nigeria. Family physicians are trained doctors who have the expertise to provide care at the primary level, although this is not the case in Nigeria, given that the family physicians are rather linked with the

referral level of care.⁴²

Aside from the perception of the need to have a medical test that is unattainable at the PHC facilities, the healthcare providers also had a negative perception of the general environment of the PHC facilities, which they felt might likely influence the decision of the patients to bypass them. Likewise, in France and the UK the availability of resources, such as laboratory tests and radiography, were one of the advantages for patients presenting at the emergency department of a referral facility.^{34,41} In a study carried out in Saint Vincent and the Grenadines, it was not only the absence of attending doctors but also the absence of diagnostic facilities that further necessitated their participants to seek care at the referral facility.⁴⁶ One of the themes that emerged from another study was the perceived need by patients to have a diagnosis. Thus, most of their interviewed patients had the perception that they would need an x-ray and so felt no need to see their General Practitioner (GP) because of the idea that they would still be sent to the emergency department. Therefore, they decided to self-refer.⁴¹ In an interview conducted among healthcare providers and patients, it was revealed that the availability of resources, such as laboratory tests and radiography, prompted patients to present at the emergency department. Furthermore, the availability of medication at the same place served as an attractive attribute for the patients to receive a complete package of care at a single place.³⁴ In contrast, the healthcare providers (nurses, doctors, and paramedics) in a study conducted in the Republic of Ireland emphasised that service users' perceptions of their need for certain investigations is not always accurate.³³

Healthcare providers in this current study revealed that presenting at the primary level of care was, for the patients, a waste of time and resources. This was based on the notion that patients were unlikely to get the care they needed despite spending their money and time at the primary level, thus were still likely to end up attending a higher level of care facility. The healthcare providers in this present study also felt that the relationship between patients and healthcare providers was a likely barrier in seeking care at a particular facility. Participants pointed out that the 'rapport' of some healthcare providers with their patients at the primary level of care was poor. Similarly, in a study from Tanzania, it was ascertained that the caretakers in their study felt that the healthcare providers within the PHC facilities lacked compassion for their sick children. They noted that the caretakers sometimes received ill-mannered responses from the healthcare providers – such as being yelled at – which, in turn, occasionally influenced their decisions to avoid those facilities.³¹ Likewise, it's been reported that a critical aspect in the delivery of quality care is not only related to the knowledge and skills of the healthcare professionals but also the attitudes of the health professionals as perceived by the users.³⁶

In this study, the healthcare providers highlighted the socioeconomic status of patients as a potential factor for utilising either healthcare facility. However, despite this assumption, it is perceived that patients would still rather use the referral facilities because of the quality of care. In a study conducted in the US among patients of low socioeconomic status, they found that their participants viewed hospital care as more affordable than primary care because uninsured patients could not afford the fees for regular primary care visits and, therefore, relied on hospital charity when they fell ill.²³ In contrast, the healthcare providers in the current study pointed out that the perceived higher cost of care at the secondary facilities could be due to the

extended services provided at these facilities, such as the investigations carried out at the secondary level facilities. Notably, the Nigerian healthcare system is majorly funded through out-of-pocket payments from patients, which is likely to influence the choice of facility for healthcare. Therefore, due to the type of funding (such as insurance, general taxation, or out-of-pocket) for healthcare systems in different settings, this could impact on how patients use the healthcare services available to them.

The irregular nature of how the PHC facilities operate, such as the opening times and closure of the facilities for a period of time, was discussed as being a potential factor encouraging the use of higher levels of care. However, some of the healthcare providers remarked that this could be linked to the shortage of staff. They emphasised that some community activities, such as immunisations, occasionally warrant the PHC facilities to be closed. Similarly, in the Caribbean it was found that the limited scheduling of doctor-run clinics and the limited hours of the clinics motivated patients to self-refer to the accident and emergency department.⁴⁶ For others, the inability to use their PHC facilities during regular opening hours due to conflicts with their work schedule prompted them to present at the referral facility.^{23,47} Additionally, some of the studies carried out in settings such as the US, Australia, and France showed that the inability to get appointments with their primary care providers, or the long waits to get appointments, were responsible for people seeking care at the referral facility.^{23,34,47–49}

The healthcare providers suggested the need to institute financial charges for patients who self-refer directly to the referral facilities in order to deter them from doing so. In line with this finding, a study carried out in France also reported that the imposition of financial penalty on patients who inappropriately use referral facilities was suggested among the healthcare providers in their study.³⁴ Nevertheless, any government policies in this regard will need to be critically evaluated, as well as being context specific.

Other suggestions proffered during the interviews with the healthcare providers as a potential means of addressing the patients bypassing the PHC facilities included the need to improve the healthcare provider-patient relationship, by ensuring good rapport and access to the healthcare providers when needed. The necessity to have adequate, trained, and qualified healthcare providers – with specific emphasis on medical doctors – stationed within the PHC facilities was also highlighted. Also, of note was the need for collaboration between the different levels of care, as current services appeared fragmented. There were also suggestions for facilities/equipment to be put in place at the primary level of care. These included renovation of the physical structures of the PHC facilities, availability of medications, and provision of equipment for investigations. Equitable distribution of PHC facilities was also proposed. In addition, a reduction in cost of providing healthcare services was advised, particularly as the Nigerian healthcare system is majorly funded by out-of-pocket payments.

The limitations of this study were that all the interviews of the current study were conducted during working hours on the premises of the health facilities, which might have impacted on the level of depth the participants were willing to talk about an issue in order to save time and complete their jobs for the day. Despite this limitation, the data that was collected reveals the complexities and the richness of the area of research. Aside from the fact that participating in this study was purely voluntary, the researcher's back-

ground as a healthcare provider appeared to have influenced the research process in a positive way, in terms of gaining access to the healthcare facilities and fostering the interview relationship with the healthcare providers. Accordingly, the concept of reflexivity in qualitative research acknowledges the input of the researchers in actively co-constructing the situation which they want to study.⁵⁰ Besides, the use of probing questions also helped to elicit specific answers from the participants. This study was also only conducted among the healthcare providers of the primary and secondary healthcare facilities; healthcare providers within the tertiary facilities were not included, thus their perceptions might have differed from the current findings.

CONCLUSION

The results from this study highlighted a number of contextual issues implicated in the bypassing of the PHC facilities, which will also need a contextual approach in order to address them. The findings suggest that factors such as the lack of manpower within the PHC facilities (especially the services of doctors), shortages and inequitable distribution of PHC facilities, lack of basic equipment within the PHC facilities, and out-of-pocket payment need to be given due consideration amongst other factors to ensure an improved healthcare referral system in Nigeria. In addition, the findings from this study have implications for planning, practice, and policy in service delivery aimed at curtailing the bypass of the PHC facilities. Future studies may aim at a quantitative examination of the identified factors in this study in order to enable generalisation.

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Consent for publication: All participants provided consent to publish anonymised data via the ethics approval.

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had substantial contribution to the development of all aspects of this study and the manuscript. All authors read and approved the final manuscript.

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